MDR Tracking Number: M5-04-2054-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 03-09-04.

The IRO reviewed office visits, materials and supplies, joint mobilization, myofascial release, therapeutic procedures, therapeutic exercises, ROM measurements, unlisted thereapeutic procedures, chiropractic manual treatment, paraffin bath rendered from 04-11-03 through 08-08-03 that were denied based upon "U".

The IRO determined that office visits, materials and supplies, joint mobilization, myofascial release, therapeutic procedures, therapeutic exercises, ROM measurements, unlisted therapeutic procedure, chiropractic manual treatment, paraffin bath from 04-11-03 through 07-15-03 **were** medically necessary. The IRO determined that office visits, materials and supplies, joint mobilization, myofascial release, therapeutic procedures, therapeutic exercises, ROM measurements, unlisted therapeutic procedure, chiropractic manual treatment, paraffin bath from 07-16-03 through 08-08-03 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee. The respondent raised no other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 06-03-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99205 date of service 04-11-03 denied with denial code "F". Per the 96 Medical Fee Guideline Evaluation and Management GR VI(A) reimbursement in the amount of $103.00 (MAR of $137.00 minus payment of $34.00 by carrier) is recommended.

CPT code 99070 dates of service 08-08-03 through 09-23-03 (4 total) denied with denial code "E"
(entitlement). No TWCC-21 is on file. These services are reviewed as fee issues. Reimbursement in the amount of $102.00 is recommended.

CPT code 99211-25 dates of service 08-11-03 through 09-17-03 (6 total) were denied with denial code “E” (entitlement). No TWCC-21 is on file. These services will be reviewed as fee issues. In accordance with the Medicare program reimbursement methodologies and Commission Rule 134.202c) reimbursement in the amount of $140.16 ($18.69 X 125% = $23.36 X 6 DOS) is the MAR. However, the requestor billed $23.35 for each date of service. Reimbursement is recommended in the amount of $140.10.

CPT code 97110 dates of service 08-11-03 through 09-08-03 (5 total) were denied with denial code “E” (entitlement). No TWCC-21 is on file. These services will be reviewed as fee issues. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

CPT code 97018 dates of service 08-11-03, 08-21-03 and 08-22-03 denied with denial code “E” (entitlement). No TWCC-21 is on file. These services are reviewed as fee issues. In accordance with the Medicare program reimbursement methodologies and Commission Rule 134.202(c) reimbursement in the amount of $22.65 ($6.04 X 125% = 7.55 X 3 DOS) is the MAR. However, the requestor billed $7.54 for each date of service. Reimbursement in the amount of $22.62 ($7.54 X 3)
is recommended.

CPT code 97139-EU dates of service 08-11-03 through 09-23-03 (8 total) denied with denial code “E” (entitlement). No TWCC-21 is on file. These services are reviewed as fee issues. In accordance with the Medicare program reimbursement methodologies and Commission Rule 134.202(c) reimbursement in the amount of $146.08 ($14.61 X 125% = $18.26 X 8 DOS) is the MAR. However, the requestor billed $18.25 for each date of service. Reimbursement in the amount of $146.00 is recommended.

CPT code 98943 dates of service 08-11-03 through 09-08-03 (4 total) denied with denial code “E” (entitlement). No TWCC-21 is on file. These services are reviewed as fee issues. Reimbursement in the amount of $111.88 ($27.97 X 4 DOS) is recommended.

CPT code 99212-25 dates of service 08-19-03 and 09-12-03 denied with denial code “E” (entitlement). No TWCC-21 is on file. These services are reviewed as fee issues. In accordance with the Medicare program reimbursement methodologies and Commission Rule 134.202(c) reimbursement in the amount of $83.82 ($33.53 X 125% = $41.91 X 2 DOS) is the MAR. However, the requestor billed $41.91 on date of service 08-19-03 and $20.96 on date of service 09-12-03. Reimbursement in the amount of $62.87 ($41.91 plus $20.96) is recommended.

CPT code 97024 dates of service 08-19-03 through 09-17-03 (5 total) denied with denial code "E" (entitlement). No TWCC-21 is on file. These services are reviewed as fee issues. In accordance with the Medicare program reimbursement methodologies and Commission Rule 134.202(c) reimbursement in the amount of $27.70 ($4.43 X 125% = $5.54 X 5 DOS) is the MAR. However, the requestor billed $5.53 for each DOS. Reimbursement in the amount of $27.65 ($5.53 X 5 DOS) is recommended.

CPT code 99213 date of service 09-11-03 denied with denial code "E" (entitlement). No TWCC-21 is on file. This service will be viewed as a fee issue. In accordance with the Medicare program reimbursement methodologies and Commission Rule 134.202(c) reimbursement in the amount of $59.00 ($47.20 X 125%) is the MAR. However, the requestor billed $29.50 therefore reimbursement in the amount of $29.50 is recommended.

CPT code 95851 (2 units) date of service 09-11-03 denied with denial code "E" (entitlement). No TWCC-21 is on file. This service will be viewed as a fee issue. In accordance with the Medicare program reimbursement methodologies and Commission Rule 134.202(c) reimbursement in the amount of $61.22 ($24.49 X 125% = $30.61 X 2) is the MAR. However, the requestor billed $30.60 per unit. Reimbursement is recommended in the amount of $61.20 ($30.60 X 2) is recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003 and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission rule 134.202(c) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04-11-03 through 09-23-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 28th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

May 14, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2054-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ------ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The ------ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 47 year-old female who sustained a work related injury on ------. The patient reported that while at work, she fell injuring her left breast, shoulder, knee, and hip. The patient was evaluated in the emergency room and was reported to have undergone a left wrist x-ray, left x-ray that were reported as not showing any fractures. On 4/11/03 the patient presented to the treating clinic and began treatment. The diagnoses for this patient have included neck sprain/strain, grade II, thoracic sprain/strain, grade II, lumbar sprain/strain, grade II, totator cuff sprain/strain, grade II left, bursitis, tendonitis of the left shoulder, elbow sprain/strain, grade II left, wrist sprain/strain, grade II, left, sprain/strain left hip and thigh, left knee sprain/strain, grade II, myofascial pain syndrome, and deconditioning syndrome. Treatment for this patient's condition has included myofascial release, therapeutic procedures, therapeutic exercises, manual treatment, joint mobilization and paraffin bath.

Requested Services

Ov, mat and supplies, joint mobil, myofas rel, ther proc, ther exer, rom measure, unlisted ther proc, chiro man treatment, paraffin bath from 4/11/03 through 8/8/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. SOAP/Therapeutic Procedure notes 4/11/03 – 9/23/03

Documents Submitted by Respondent:

1. No Documents Submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ------ physician reviewer noted that this case concerns a 47 year-old female who sustained a work related injury to her left breast, shoulder, knee and hip on ------. The ------ physician reviewer indicated that this patient sustained multiple soft tissue injuries and various sprains/strains, developed myofascial pain and was treated with chiropractic treatment from 4/11/03 through 8/8/03. The ------ physician reviewer noted that the patient had been given ice packs and biofreeze for home use and instructed on how to perform exercises at home. The ------ physician reviewer indicated that the progress notes provided show mobilization, treatments, therapeutic exercises and generalized conditioning exercises. The ------ physician reviewer explained that the progress notes provided do not show that paraffin bath treatments were given at each visit and that different modalities were used at various visits. The ------ physician reviewer noted that 1 range of motion measurement was provided that was dated 7/17/03. The ------ physician reviewer explained that the patient's pain level remained a 7-8/10 since the initiation of this treatment. The ------ physician reviewer indicated that the only objective improvement documented is the patient's ability to walk without a cane on 7/17/03. The ------ physician reviewer explained that this patient required treatment sessions from 4/11/03 through 7/15/03. The ------ physician reviewer also explained that this patient failed to show improvement after 7/15/03 and could have been instructed on a home based exercise program. Therefore, the ------ physician consultant concluded that the ov, mat and supplies, joint mobil, myofas rel, ther proc, ther exer, rom measure, unlisted ther proc, chiro man treatment, paraffin bath from 4/11/03 through 7/15/03 were medically necessary to treat this patient's condition. However, the ------ physician consultant further concluded that the ov, mat and supplies, joint mobil, myofas rel, ther proc, ther exer, rom measure, unlisted ther proc, chiro man treatment, paraffin bath from 7/16/03 through 8/8/03 were not medically necessary to treat this patient's condtion.

Sincerely,
